

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION MANUAL

SECTION III - CONDITIONS OF PARTICIPATION

I. Utilization Review

AIS/MR case management providers shall reevaluate the client's Individual Habilitation Plan every six (6) months and submit it to the Department for Medicaid Services for review and approval. The reevaluation by state Medicaid program staff of the revised individual habilitation plan in conjunction with the previously submitted information includes a determination as to whether all criteria are met for AIS/MR service coverages; (1) the client's care needs meet the Intermediate Care Facility (ICF) MR/DD level of care criteria as determined by the peer review organization, and (2) the individual habilitation plan is adequate and appropriate to meet the client's service needs effective on an overall basis and (3) the cost worksheet reflects that there is a reasonable expectation that AIS/MR services would be less expensive than institutional services the client would otherwise receive in an ICF/MR/DD.

In addition to the individual habilitation plan review, an on-site review is conducted by the Department for Medicaid Services (DMS) staff at least annually with the primary purpose of determining whether the services are adequate to meet the health, habilitative, and social needs of each individual, and that the client is receiving active treatment to promote his maximum physical and mental functioning. During the on-site review, a sample of clinical records maintained by the provider is reviewed and selected clients are visited. This review includes an assessment of the client's continued eligibility for AIS/MR service benefits, the appropriateness of services to the client's care needs and the quality of service provided.

The DMS professional staff conducting the POC and on-site reviews shall include at least one (1) registered nurse, and other appropriate health and social service personnel. The social services personnel shall have a Bachelor of Arts degree and meet Kentucky's requirements for that position. At least one (1) member of the review team shall be knowledgeable of the problems and needs of persons with mental retardation. (Refer to Appendix [XIV]).

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Provider records shall be reviewed to consider at least the following:

1. Is the individual habilitation plan compatible with identified needs?
2. Does the individual habilitation plan indicate the recipient's functional abilities and disabilities? Is the plan individualized?
3. Are strengths and needs identified?
4. Is the individual habilitation plan realistic to achieve objectives?
5. Does the individual habilitation plan identify scope and amount of services?
6. Does the individual habilitation plan identify the providers of the proposed services including informal and formal care givers?
7. Are the service goals and objectives stated in a way so that client progress can be measured? Does it indicate how progress is to be measured and with what regularity?
8. Is the plan clear enough that new staff could take over?
9. Are potential problems identified and contingency plans developed?
10. Does the plan reflect the client's and family's involvement in the development of the plan?
11. Are there provisions for a reassessment included in the plan? (This may be included on the IHP Summary page.)
12. Are the services adequate to meet the health habilitation and social needs of the client?

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The on-site review shall be used to verify that no prevocational and supported employment services are provided through the waiver if the client is receiving these services under the Rehabilitation Act of 1973 or the Education of the Handicapped Act or has not been deinstitutionalized.

One function of the on-site review includes a sample review of the client records to assure that services billed were performed and that the services were performed in accordance with the approved individual habilitation plan.

Another aspect of the on-site review is a sample review of the financial records to assure that adequate records are maintained to document that the services billed were provided.

Where services were billed inappropriately, e.g., not included in the individual habilitation plan, the Medicaid State Agency may recoup the payment for those services.

Where utilization review results indicate less than adequate services to meet the special care needs of the clients, AIS/MR service coverage may be discontinued.

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J. Guardianship

It is required that staff maintain appropriate contact and reporting with Guardianship Office as required in the Statement of Responsibility of Guardianship (Appendix XVII). Staff are also required to maintain contact with the legal representative for each client.

K. Termination of Provider Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department for Medicaid Services' administrative regulations which address the terms and conditions for provider termination and procedures for provider appeals.

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IV. Services Covered

A. Introduction:

1. Covered services of the AIS/MR Program are as follows:

a. Case Management

b. Residential Care:

1. Staffed Residence
2. Group Home
3. Family Home

c. Day Habilitation:

1. Adult
2. Children
3. Pre-Vocational Employment
4. Supported Employment

d. In-Home Training

e. Homemaker/Home Health Aide

f. Personal Care

g. Habilitation

1. Behavior Management
2. Psychological Services
3. Occupational Therapy
4. Speech Therapy
5. Physical Therapy
6. Expressive Therapy
7. Therapeutic Recreation
8. Leisure Services
9. Medical Items/Services

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h. Respite

Multi-Service Providers

Any qualified AIS/MR provider may choose to provide one or more of the above-listed services. If more than one service is provided by the same provider, the provider is considered to be a multi-service provider.

2. ALL AIS/MR CLIENTS SHALL MEET ALL THREE OF THE FOLLOWING CRITERIA:

- A. Meet level of care criteria for an ICF/MR/DD facility:
- B. Need active treatment as demonstrated through appropriate assessment and as determined by an inter disciplinary team. Active treatment is defined as:

An ongoing program of services which are directed toward the client's acquisition of behaviors and skills needed to function more independently or to prevent or decelerate regression or loss of current optimal functional status which would result in placement in a more restrictive environment.

Active treatment includes:

1. Day Habilitation

Medicaid Covered

- a. Adult Day Habilitation
- b. Children's Day Habilitation
- c. Pre-vocational Services for OBRA-eligible clients
- d. Supported Employment for OBRA-eligible clients

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Non-Medicaid Covered

- e. Services provided to clients identified as eligible for and receiving services under P.L. 94-142 and Section 619 and Part H of P.O. 99-457
- f. Sheltered Employment
- g. Prevocational Services for Non-OBRA eligible clients
- h. Supported Employment for Non-OBRA eligible clients
- 2. In-Home Training Services
- 3. Residential Care Services
- 4. Habilitation Services

C. Need and receive, in accordance with the client's plan of care, at least the following:

- 1. Case Management Services
- 2. Day Habilitation Services (whether or not they are Medicaid covered), and
- 3. Residential Care Services

OR

In-Home Training Services

OR

An on-going program of habilitation services when those are designed and directed toward the client's acquisition of behaviors and skills needed to function more independently or to prevent or decelerate regression or loss of current optimal function status which would result in placement in a more restrictive environment, e.g. behavior management or recreation therapy.

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In addition to the above criteria all AIS/MR clients initial plan of care and interval six (6)-month plan of care updates shall be reviewed by the Department of Medicaid Services staff for appropriateness of placement in the AIS/MR program.

B. Case Management:

1. Definition of Service

Case management services are services which assist the client in gaining access to needed social, medical, educational, and other support services with the purpose of helping the client to become more independent.

The case management provider is responsible for the health, safety, and welfare of the client. EACH CLIENT RECEIVING AIS/MR SERVICES SHALL SELECT A CASE MANAGEMENT PROVIDER WHO PROVIDES THE POINT OF ENTRY INTO THE AIS/MR PROGRAM AND PROVIDES FOR CONTINUITY OF CARE THEREAFTER.

Responsibilities of the case management provider include:

- a. Intake
- b. Evaluation and Assessment
- c. Providing information on accessing needed services
- d. Assuring freedom of choice of providers
- e. Assisting in the development of the client's plan of care
- f. Coordinating programs and services
- g. Monitoring services provided
- h. Providing support services to the client such as appointing and overseeing a human rights committee and by providing 24-hour telephone access to a case management staff person.

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a. Intake:

Intake includes the gathering of information that is needed for the level of care determination and obtaining the level of care (ICF/MR/DD) determination and verification of or assistance with Medicaid eligibility. This service is performed for all persons seeking AIS/MR services, whether the client will be residential or in-home.

b. Evaluation and Assessment:

The evaluation and assessment includes the establishment and maintenance of a core residence. The core residence is located in the community setting. It provides an entry, evaluation, and assessment site for residential clients.

All residential clients shall have a core stay of no less than seven (7) days and no greater than ninety (90) days. In-home clients are not required to have a core stay.

The core stay provides time for the case management provider to perform a residential needs assessment and an evaluation for each client. The residential needs assessment is the process of identifying the specific residential needs of the client. The evaluation of the client determines the appropriate individualized residential placement suited for that client. In addition, the case management provider identifies which support services the client needs in order to be maintained in the community.

The core residence may also be used for transition purposes, i.e., if there is a change in the placement, the client may need to return to the core for reevaluation. While in-home clients are not required to have a core stay, in-home clients who become residential clients are required to have a core stay.

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Payment for any room and board in the core stay is the responsibility of the client or guardian. No Medicaid payment shall be made for room and board. In addition, all AIS/MR clients, whether residential or in-home, shall receive an evaluation to determine services needed.

After evaluation and assessments are performed, the case management provider shall place the residential client in a community setting.

c. Providing information on accessing needed services:

Access includes making the client or his legal guardian aware of the available certified AIS/MR service providers. The case management provider shall maintain current information regarding AIS/MR providers and share the information with the client or legal guardian.

d. Assuring freedom of choice of providers:

The case management provider shall present the client or legal guardian with choices of all available Medicaid-participating AIS/MR providers of service in accordance with the client's needs as identified in a preliminary plan of care. The chosen providers shall become involved in the development of the plan of care.

e. Assisting in the development of the client's plan of care:

The case management provider shall coordinate the interdisciplinary team, write the plan of care in conjunction with other chosen service providers, and initiate the memorandum of understanding with service providers regarding plan implementation, adherence, and re-evaluation.

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f. Coordinating programs and services:

After the client or legal guardian has chosen the service providers, the case management provider shall contact those agencies and arrange for services. Provision of these services shall begin as soon as identified and consistent with the plan of care, including time during the core stay.

Service providers shall work with the case management provider to provide necessary services in accordance with the plan of care as well as input for needed changes.

g. Monitoring services provided:

Monitoring shall include monthly visits to service sites to assure compliance with the plan of care and to evaluate programs' effectiveness. Monitoring is a vital part of the case management provider's function as it is used to assure the health, safety, and welfare of the client. It involves close supervision of providers and continuous review of the services.

h. Providing support services to the client:

Support includes:

1. Assuring the availability of needed AIS/MR services;
2. Meeting with and providing information to the client or legal guardian;
3. Establishing and overseeing a human rights committee for review of overall procedures and individual behavioral plans;

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4. Providing 24-hour telephone access to a case management staff person; and
5. Maintaining a central record which includes the master plan of care, documentation of monthly site visits to service providers, assurance of freedom of choice of providers, individual service providers' plan of care, staff notes from each service provider, and other pertinent information as required.

2. Procedure Codes:

- a. Intake, evaluation, and core stay (up to fourteen (14) days)
(For Residential Clients)
 1. Procedure Codes: X0064
 2. Unit of Service: one (1) unit
 3. Documentation: Summary Note
Note: The first fourteen days are equal to one (1) unit of service.
- b. Intake and Evaluation (For In-Home Clients)
 1. Procedure Code: X0074
 2. Unit of Service: one (1) unit
 3. Documentation: Summary Note
Note: The intake and evaluation is equal to one (1) unit of service.
- c. Residential Continuing Evaluation and Core Stay
(From Day 15 through Day 90) (For Residential Clients)
 1. Procedure Code: X0075
 2. Unit of Service: twenty-four (24) Hours =
one (1) Unit
 3. Documentation: Summary Note at least weekly
- d. Ongoing Case Management
 1. Procedure Code: X0076
 2. Unit of Service: one (1) month = one (1) unit
 3. Documentation: Summary Note at least bi-monthly

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- e. Transition (For clients who return to the core for a temporary stay)

1. Procedure Code: X0077
2. Unit of Service: twenty-four (24) hours =
one (1) unit
3. Documentation: Daily Note

C. Residential Care:

A residential care provider may provide any one or all of the following services:

1. Group Home Services
2. Staffed Residence Services
3. Family Home Services

Residential care providers, regardless of which or all of the above-listed services they provide shall:

1. As necessary, participate in the interdisciplinary team meetings.
2. Provide residential training designed to facilitate the acquisition of communication skills, sensorimotor, and self-help skills.
3. Assist with daily living such as ambulation, dressing, grooming, feeding, toileting, bathing, meal planning and preparation, laundry, and home care and cleaning.
4. Assist with basic health and health-related services through the continuous supervision of and monitoring of the client to assure that the client's healthcare needs are being met, supervise self-administered medication, storage and control of medications, and cooperate and coordinate with the case management provider to obtain healthcare services as necessary, and in obtaining the services of a physician in case of accident or acute illness of the client.

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1. Definitions:

a. Group Home Residential Services:

Group home providers shall hold a current license, as such, in accordance with 902 KAR 20:078. No more than three (3) AIS/MR clients shall reside in a single group home residence.

b. Staffed Residence Services:

A staffed residence provider is an organization providing residential care. A staffed residence provider provides twenty-four (24) hour supervision, training, and assistance with daily living needs. No more than three (3) clients shall be maintained in each staffed residence.

c. Family Home Residential Services:

A family home provider provides twenty-four (24) hour supervision, training, and assistance with daily living needs of clients in a home. A family home shall serve no more than three (3) clients. The home is shared by the client(s) and the family home's direct-contact care giver.

2. Procedure Codes:

Group Home Services:

- a. Procedure Code: X0088
- b. Unit of Service: twenty-four (24) hours = one (1) unit
- c. Documentation: A summary note at least weekly

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Staffed Residences:

- a. Procedure Code: X0061
- b. Unit of Service: One (1) day (24 hours) = one (1) unit
- c. Documentation: A summary note at least weekly

Family Home:

- a. Procedure Code: X0089
- b. Unit of Service: One (1) day (24 hours) = one (1) unit
- c. Documentation: A summary note at least weekly

D. Day Habilitation:

Day Habilitation consists of four (4) types of organized programs of training in developmental skills in non-residential, non-inpatient settings using age-appropriate methods which enable the client to attain or maintain his maximum functional level. Clients may receive one or more of these programs in accordance with his individual plan of care.

Day Habilitation programs are provided for a minimum of four (4) hours per day, five (5) days per week, twelve (12) months per year, excluding major holidays.

A client shall attend at least one day habilitation program. If a client's needs indicate that participation in more than one day habilitation program is beneficial to the client, a client may attend more than one program. However, regardless of the number of programs attended, the client shall receive at least four (4) hours per day of day habilitation as referenced above.

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The four (4) types of programs available under Day Habilitation are Adult Day Habilitation, Children's Day Habilitation, Pre-vocational Services, and Supported Employment.

1. Adult Day Habilitation (ADH):

a. Definition:

Adult Day Habilitation programs are for clients age eighteen (18) years and older.

Adult day habilitation generally includes the following types of activities:

1. Self-help skills (including eating and drinking skills, motor and perceptual skills, personal hygiene, dressing and grooming, toileting, general health care, clothing maintenance, shopping and housekeeping skills);
2. Communication (including language development, signing, use of media, telephones, etc.); and
3. Interpersonal, social, and adaptive skills (including number, time, and spatial concepts; following a routine; developing appropriate habits and skills for the completion of purposeful activities; following directions; transportation and mobility training; communication and interactions with disabled and non-disabled peers and trainers; and using break area, lunch room and community resources).

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Purposeful activities and not work or production are the main emphasis of adult day habilitation services. For clients entering adult day habilitation services, there is not a reasonable expectation that they will be able to participate in sheltered employment or in the general work force within one (1) year.

For clients who have substantial behavior problems that would preclude acceptance on a full-time basis in an existing ADH program, an alternative, individualized program that would include behavior management and training may be considered by the Department on a time-limited basis. This shall be approved in writing by the DMS and Division of Program Services prior to initiation of the program.

Additionally, a reduction in the required number of hours, days, or location for a specific individual, may be considered on a time-limited basis with valid justification, such as medical illness. This shall also be prior approved in writing by the DMS.

For all clients, the goal shall be full-time attendance in a recognized Day Habilitation Program.

Requests for specialized or reduced ADH Programs shall be sent to:

Department for Medicaid Services
CHS Building, 3rd Floor, East Wing
275 East Main Street
Frankfort, KY 40621

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NOTE: Covered Habilitation services, such as speech, physical, occupational, and expressive therapy, may be provided at the site of the Day Habilitation Program during the time a client is in attendance, but it shall not be counted as a part of the required four (4) hours, five (5) days day habilitation services.

However, the time spent in the therapies shall be clearly documented and separated from the time spent in day habilitation and be billed as a separate service.

For example: If the client attends day habilitation from 10:00 a.m. until 3:00 p.m. but has speech therapy from 1:00 p.m. to 2:00 p.m.; only 4 hours can be billed as day habilitation. The remaining 1 hour is to be billed as speech therapy.

Limitations:

1. ADH services may be provided on an individual basis or in group settings. In either case, written, measurable skills development objectives must be documented. Staff notes must address these identified objectives.
2. If ADH services are provided in a group setting, the program shall employ a minimum of two (2) supervisory staff for the first ten (10) clients or fewer.
3. When there are over ten (10) clients in the ADH program, one (1) additional employee shall be in direct client service for each additional group of five (5) or any part thereof.

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4. Services shall be provided in accordance with the client's plan of care specifying services to be provided.

5. No Medicaid payment shall be made for public schools or community education.

b. Procedure Code

1. Procedure Code: X0066
2. Unit of Service: one (1) hour
3. Documentation: Weekly Summary Note

2. Children's Day Habilitation:

a. Definition:

Children's day habilitation programs for clients under age twenty-two (22) who are enrolled in school may be provided for up to five (5) days per week during the summer months when school is not in session. Children's habilitation services should follow the plans and goals identified in the Individual Education Plan (IEP) or the Individualized Family Services Plan (IFSP) for each child. Summer recreational activities may be utilized in working toward these goals.

Services may be offered either in a group or individual setting. They shall be provided by staff whose credentials and training and experience meet at least the minimum criteria set for all other day habilitation staff. Services should be performed outside the child's home, except when not feasible due to a medical condition.

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Limitations:

1. CDH services may be provided on an individual basis or in group settings. In either case written, measurable skills and objectives shall be documented. Staff notes must address these identified objectives.
2. If CDH services are provided in a group setting, the program shall employ a minimum of two (2) supervisory staff for the first ten (10) clients or fewer.
3. When there are over ten (10) clients in the CDH program, one (1) additional employee shall be in direct client service for each additional group of five (5) or any part thereof.
4. Services shall be provided in accordance with the client's plan of care specifying services to be provided.
5. No Medicaid payment shall be made for public schools or community education.

b. Procedure code:

1. Procedure Code: X0073
2. Unit of Service: one (1) hour
3. Documentation: Weekly Summary Note

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3. Prevocational Services:

a. Definition:

Prevocational services are aimed at preparing a client for paid or unpaid employment and which assists him in acquiring and maintaining basic work and work-related skills. This does not include on-the-job training. When compensated, clients are paid less than fifty (50) percent of minimum wage.

Coverage for prevocational services is available only to clients who are deinstitutionalized from a nursing facility or ICF/MR/DD facility. The deinstitutionalization need not have occurred immediately prior to the receipt of waiver services. Clients who are unable to participate in prevocational services for four (4) to six (6) hours per day may also be involved in adult day habilitation services.

1. Prevocational services shall be designed to assist the client in adjustment to a work environment through the following:
 - (a) Assisting the client toward his optimal vocational development;
 - (b) Assisting the client to understand the meaning, value and demands of work;
 - (c) Assisting the client to learn or reestablish skills, attitudes, personal characteristics, and work behaviors; and
 - (d) Assisting the client to develop functional capacities.

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2. The agency shall not include as prevocational services training or preparation for a specific job or job title.
3. Prevocational services may include but are not limited to the following:
 - a. Development of physical capacities such as sitting, standing, and general work stamina;
 - b. Development of psychomotor skills; e.g., eye-hand coordination, finger dexterity, and tool usage;
 - c. Interpersonal and communicative skills; e.g., relations with supervisor, co-workers;
 - d. Development of appropriate work behavior and characteristics; e.g., adaptation to routine, punctuality, dress;
 - e. Development of work performance skills; e.g., job production and performance, work pacing;
 - f. Development of work-related functional living skills; e.g., mobility which includes the use of public and paratransit systems, time and money management;
 - g. Training in the use of assistive devices and aids;
 - h. Training in the use of job-related facilities; e.g., break areas, lunch rooms, cafeterias, and toilets; and
 - i. Job seeking and keeping skills; e.g., interviewing, completion of application forms and understanding evaluation practices.

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4. The agency shall limit the time that a client remains in a prevocational program to that which is necessary to accomplish the client's goals which are relevant and age-appropriate as identified in his written plan of care.

b. Procedure Code:

- (1) Procedure Code: X0078
- (2) Unit of Service: one (1) hour
- (3) Documentation: Weekly Summary Note

4. Supported Employment:

a. Definition

Supported employment means paid work in a variety of work settings in which clients with mental retardation/developmental disabilities are employed. These work settings are matched to the client to assist on-the-job functioning irrespective of age or vocational potential, and

- (1) for whom competitive employment at or above the minimum wage is unlikely and
- (2) who, because of their disability, need intensive ongoing support to perform in a work setting.

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Coverage for supported employment services is available only to clients who are deinstitutionalized from a nursing facility or ICF/MR/DD facility. The deinstitutionalization need not have occurred immediately prior to the receipt of waiver services. Clients who are unable to participate in supported employment for four (4) to six (6) hours per day may also be involved in adult day habilitation services.

The term supported employment encompasses the following types of activities designed to assist eligible clients access to and maintaining employment:

- (1) individualized assessment;
- (2) individualized job development and placement services that produce an appropriate job match for the client and his employer;
- (3) on-the-job training in work and work-related skills required to perform on the job;
- (4) ongoing supervision and monitoring of the client's performance on the job;
- (5) ongoing support services necessary for performance in a work setting;
- (6) training in related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation and mobility training.

NOTE: Ongoing support services (see (5) above) could involve a variety of facilitative or support services on an as-needed basis. This may include staff intervention to resolve problems in the areas of housing, transportation, personal care, behavior, family involvement, or any situation which affects the individuals getting to the job and retention of that job.

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b. Procedure Code:

- (1) Procedure Code: X0079
- (2) Unit of Service: one (1) hour
- (3) Documentation: Weekly Summary Note

E. In-Home Training Services:

1. Definition:

In-home training is the provision of services to a client which assist him with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the client to reside in a community setting. Payment for in-home training shall not be made, directly or indirectly, to members of the client's immediate family. Payments shall not be made for routine care and supervision of the client which would normally be expected to be provided by the family or family members. In-home training services shall not be duplicative of homemaker or personal care services and the plan of care shall specify in-home training activities to eliminate any duplication. Services to or for the benefit of family members other than the client are not covered.

In-home training provides developmental and functional skills training in the client's home or a setting which is commonly used as an extension of routine home life; i.e., the grocery, the laundromat, pharmacy, or clothing store. When these services are provided outside the home, it shall be on a time limited basis, appropriate to the capabilities of the client, and shall be justified in the plan of care.

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In order for the activity to be considered training, measurable objectives shall be set, tasks shall be specified, and data must be kept.

The in-home trainer may participate in the interdisciplinary teams as requested.

Procedure Code:

- (a) Procedure Code: X0067
- (b) Unit of Service: 1/4 hour (15 minutes)
- (c) Documentation: Staff notes per date of service

F. Homemaker and Home Health Aide Services:

1. Definition:

Homemaker and Home Health Aide services are services which provide assistance with routine household activities for the benefit of the client.

This service is provided by a trained provider when the individual regularly responsible for these activities is unable to manage the home and himself or the client and arrangements can not be made with other relatives or friends to provide the service.

Services include the provision of laundry services, meal planning and preparation, grocery shopping, and light housekeeping for the benefit of the client.

This service does not include the cost of the meals which are prepared. Nor does it include services for the benefit of family members.

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2. Procedure Code:

- (a) Procedure Code: X0068
- (b) Unit of Service: 1/4 hour (15 minutes)
- (c) Documentation: Staff note per date of service

G. Personal Care Services:

1. Definition:

Personal care services are services provided to the AIS/MR client in accordance with his individualized plan of care to assist the client in ambulation, dressing, toileting, grooming, feeding, bathing, and other necessary daily living skills.

2. Procedure Code:

- (a) Procedure Code: X0069
- (b) Unit of Service: 1/4 hour (15 minutes)
- (c) Documentation: Staff note per date of service

H. Habilitation Services:

1. Definition:

Habilitation services are services which assist the client to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and environment and to raise the level of his physical, mental, and social functioning.

The primary focus of habilitation services is therapeutic treatment developed specifically for the individual client. Habilitation services shall be provided by professionals, so qualified by education, training, and licensure if required.

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Habilitation services include behavior management, psychological services, occupational therapy, speech therapy, physical therapy, expressive therapy, leisure recreation services, therapeutic recreation services, and medical services or items if not otherwise covered by any other service element of Kentucky Medicaid. Habilitation services are available to both adults and children when not required to be provided by local schools and when directed at the resolution of problems not associated with mental illness.

Habilitation services include:

(a) Behavior Management:

Behavior management is the identification and definition of techniques to be used by care givers when interacting with the client which are directed toward modification of maladaptive or problem behaviors. It includes the training of care givers in the use of techniques and appropriate and accurate recording of the client response and evaluation of the techniques to include updating as needed.

It is the use of a planned systematic application of techniques and methods to influence or change behavior in a desired way. It is based on the belief that behaviors are learned and are maintained because of their consequence. Techniques used are to increase positive behavior and decrease undesirable behaviors. The maladaptive or problem behavior is to be replaced with behaviors that are adaptive and appropriate.

SECTION IV - SERVICES COVERED

Problem behaviors necessitating the use of behavior management are those behaviors which:

1. are a danger to the client or others;
2. result in damage to property; or
3. interfere with educational or developmental programs or interfere with the acceptance and integration into community activities.

All programming and activities shall be designed to equip the client to communicate his needs and to participate in age appropriate activities. Behavior management programs developed by the behavior specialist shall be implemented by provider staff in all relevant environments and activities.

b. Psychological Services:

The administration of psychological testing for diagnosis and evaluation.

c. Occupational Therapy Services:

Occupational Therapy shall include duties such as:

- (1) Assisting the physician in his evaluation of the client's level of functioning by applying diagnostic and prognostic tests.
- (2) Guiding the client in his use of therapeutic, creative, and self care activities for improving function.

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d. Physical Therapy Services:

Physical Therapy shall include such services as:

- (1) Assisting the physician in his evaluation of clients by applying muscle, nerve, joint, and functional ability tests.
- (2) Treating clients to relieve pain, develop or restore functions, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

e. Speech Therapy Services:

Speech Therapy shall include such services as:

- (1) Evaluation of clients with speech or language disorders.
- (2) Determination and recommendation of appropriate speech services.
- (3) Provision of necessary habilitative services for clients with speech and language disabilities.

f. Expressive Therapy Services:

Expressive Therapy is the prescribed use of art, music, drama, dance, or movement to modify ineffective learning patterns or influence change in behavior. These services provide an opportunity for verbal and non-verbal clients to communicate. Besides being able to evoke specific feelings and thoughts in the client and group, the creative arts are also very adept at stimulating verbalizations and interactions.

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g. Leisure Recreation Services:

Leisure services include participation in and training for leisure activities, structured or unstructured. These services are provided by the leisure specialist. Leisure activities center on the individual client's interests and likes. These services may be provided individually or in a group setting.

The purpose of leisure services is to provide training and integration of the client into community living. It centers on a client's likes and dislikes.

Training includes the development of knowledge, skills, and appreciation for leisure activities. Training may be in a group setting as well as individual. Groups may involve people who are not AIS/MR clients. The goal of training is to teach skills necessary for independent pursuit of leisure activities.

Limitations:

- (1) For adults, these services are limited to services that are provided after the client's normal ADH or working hours. They may be provided during the evenings and on weekends.
- (2) The client's participation or staff time involved in community sponsored/funded activities (e.g. Special Olympics) shall not be reimbursed by Medicaid.

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- (3) Services shall be provided in accordance with the client's needs, skills, and level of development as reflected in the client's individual plan of care.

h. Therapeutic Recreation Services:

Therapeutic recreation services are to improve physical growth and development, enhance motor skills, and improve cognitive abilities in accordance with the client's individualized plan of care.

Therapeutic recreation services are not diversional in nature and are to be included in the plan of care related to a specific therapeutic goal. These services are delivered on an individual basis. Therapeutic recreation shall not be provided in a group setting.

Therapeutic recreation services and leisure recreation services are not duplicative. Therapeutic recreation services are specifically designed for developmental and treatment purposes. Whereas, leisure recreation services are chosen for the client's enjoyment to integrate him into community living and to train him in the use of his leisure time.

i. Medical Services and Items:

Medical services and items are services by appropriate medical specialists and items necessary for the client's habilitation which are not otherwise covered by any other service element of the Medicaid program.

All services and items shall be prescribed by a physician or authorized by a habilitation specialist (i.e. occupational or speech therapist) or by another licensed medical specialist (i.e. a dentist) and given prior approval by the Department for Medicaid Services.

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NOTE: Prior approval by the Department for Medicaid Services is required for all items. The request shall be submitted on a Request for Equipment Form MAP-95 (See Appendix) which must include all requested information: cost of item, description of item, manufacturer's name, supplier's name, etc.

The physician's order for the item, documentation of medical necessity, and brief explanation of how the client is expected to benefit from the item is to be included with the MAP-95.

Needed pharmaceuticals not covered on the outpatient drug list may meet the criteria for pre-authorized drugs. For more information, contact the fiscal agent.

2. Procedure Codes for Habilitation Services:

(a) Behavior Management:

- (1) Procedure Code: X0080
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(b) Psychological Services:

- (1) Procedure Code: X0081
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

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(c) Occupational Therapy:

- (1) Procedure Code: X0082
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(d) Physical Therapy:

- (1) Procedure Code: X0084
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(e) Speech Therapy:

- (1) Procedure Code: X0083
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(f) Expressive Therapy:

- (1) Procedure Code: X0085
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(g) Leisure Services:

- (1) Procedure Code: X0086
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

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NOTE: The per unit rate for leisure services is based on a direct, one-to-one encounter between the client and the professional. Therefore, if these services are provided in a group setting, the cost per unit should be divided among the number of clients and billed accordingly.

(h) Therapeutic Recreation:

- (1) Procedure Code: X0087
- (2) Unit of Service: 1/4 hour (15 minutes)
- (3) Documentation: Staff note per date of service

(i) Medical Services/Items:

- (a) Procedure Code: X0099
- (b) Unit of Service: Maximum of one (1) per item/service
- (c) Documentation: Physician/Specialist order

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I. Respite Services

1. Definition

Respite services are services provided the AIS/MR client for the temporary relief of the client or the family with whom the client resides. It may be provided in a variety of settings.

Respite may be short-term care of one hour or more, it may be longer term care, up to twenty-four (24) hours or longer. Respite care shall be less than thirty (30) consecutive days.

If respite services are provided to an AIS/MR client in an ICF/MR/DD facility and paid for by Medicaid funds, the cost of the service shall be added to the client's total AIS/MR annual expenditures, and the client's allowable respite days shall be reduced by the number of institutional days.

2. Procedure Codes

- a. Daily Respite - In-Home Clients - More than twenty-four (24) hours, less than thirty (30) consecutive days.
 - (1) Procedure Code: X0070
 - (2) Unit of Service: twenty-four (24) hours = one (1) unit
 - (3) Documentation: Daily staff note up to five (5) consecutive days. Over five (5) consecutive days; weekly staff note
 - (4) Limitation: In combination with procedure code X0071, no more than sixty (60) days per recipient per calendar year.

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- b. Hourly Respite - In-Home Clients - More than one (1) hour, less than twenty-four (24) hours.
- (1) Procedure Code: X0071
 - (2) Unit of Service: One (1) hour
 - (3) Documentation: Staff note per date of service.
 - (4) Limitation: In combination with procedure code X0070, may not exceed sixty (60) accumulated days, twenty-four (24) units of the hourly respite will equal one (1) unit of the daily respite (X0070).
- c. Daily Respite - Family Home Clients - More than twenty-four (24) hours, less than thirty (30) consecutive days.
- (1) Procedure Code: X0062
 - (2) Unit of Service: twenty-four (24) hours = one (1) day
 - (3) Documentation: Institutional staff notes
 - (4) Limitations: In combination with procedure code X0063, (hourly) no more than 60 days (units) per recipient, per calendar year.
- d. Hourly Respite - Family Home Clients - More than one hour, less than twenty-four (24) hours.
- (1) Procedure Code: X0063
 - (2) Unit of Service: one (1) hour
 - (3) Documentation: Staff note per date of service
 - (4) Limitation: In combination with procedure X0062, sixty (60) days (units) per client, per calendar year. NOTE: for purposes of determining the accumulated maximum, twenty-four (24) units of procedure X0063 (hourly) will equal one (1) unit of X0062 (daily)

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e. Institutional Respite

Respite provided to AIS/MR clients in a ICF/MR/DD facility.

- (1) Procedure Code: X0072
- (2) Unit of Service - one (1) unit
Please note - the entire stay may be billed as one line item with the number of days entered in units of service.
- (3) Documentation: Institutional Staff Notes
- (4) Charge and Payment: \$0.00
- (5) Date of Service: Date of entry into institution
- (6) Limitations:
 - (a) In combination with procedure codes X0070, and X0071, and in combination with procedure codes X0062 and X0063, sixty (60) days per client per calendar year, no more than thirty (30) consecutive days.
 - (b) No other AIS/MR service is billable during client's period of institutionalization.

Institutional respite shall be audited in post-payment review.

EXCEPTION: An extension of the maximum number of respite days may be considered in a crisis situation when prior authorized in writing by the Department for Medicaid Services.

A written request identifying the crisis and outlining the reasons for the request and the number of days needed, may be submitted to:

Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

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V. ENROLLMENT OF THE CLIENT

A. Introduction

As referenced in Section IV, Services Covered, the case management provider is responsible for getting the client into the system. The case management provider performs intake services, gathers and evaluates information obtained regarding the client's condition, completes the application process and performs monitoring activities of services rendered.

The case management provider follows the criteria for determining the eligibility of individuals for admission to AIS/MR. He conducts evaluations to determine the individual's needs and if the individual is likely to benefit from services provided by AIS/MR.

The case management provider reports the results of preliminary evaluations and assessments to the potential client or his legal representative.

B. Waiting List

Each person who meets the criteria as referenced on the MAP-620, Application to AIS/MR Services, shall be able to submit this request to the Department for Medicaid Services. If the applicant meets all criteria and when there is an AIS/MR placement available, he shall be admitted to the AIS/MR Program upon acceptance of the placement and satisfactory completion of the required evaluations and admission criteria addressed in this manual.

If there are no AIS/MR placements available for eligible applicants, the applicant's name shall be entered on the AIS/MR waiting list for possible future placement.

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1) To Apply for the Waiting List

Any person who wishes to apply for placement on Medicaid's centralized waiting list shall complete a MAP-620, Application for AIS/MR/DD Services Form. A copy of this form is referenced in Appendix XX.

In addition to the necessary identifying information, the Axis II diagnosis (Mental Retardation or Developmental Disability) and a physician's statement of medical necessity for the need for active treatment shall be indicated on the MAP-620.

This form shall be submitted to the:

Department for Medicaid Services
Division of Program Services
275 East Main Street
Frankfort, Kentucky 40621

Attached to the MAP-620 shall be any written documentation of prior requests made contemporaneous with that request.

NOTE: PLACEMENT ON THE WAITING LIST DOES NOT GUARANTEE AN AIS/MR PLACEMENT OR SERVICES.

2) Waiting List Placement

The order of placement on the waiting list shall be determined chronologically by date of receipt of the MAP-620 or written documentation accompanying the MAP-620 by the Department for Medicaid Services, unless an emergency situation which meets the criteria specified below supercedes the chronological order.

In the event of multiple MAP-620 forms on the same arrival date, a lottery shall be held to determine placement on the waiting list.

Written notification of the date and placement on the waiting list shall be sent to the applicant or his legal representative and case management provider, if applicable.

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A notice of placement on the waiting list shall be mailed within ten (10) days of receipt of the MAP-620 form.

Incomplete MAP-620 forms shall be returned to the client or his legal representative and case management provider, if applicable, without placement on the waiting list.

Applicants who are denied placement on the waiting list, for reasons other than the lack of complete information on the MAP-620 Form, shall have the right to appeal as referenced in this section.

Emergency criteria shall be defined as:

- a) Death or loss of the immediate care provider,
 - b) Emergency hospitalization of the immediate care provider,
 - c) Other circumstances which relate to individual's or caregiver's situation may also be considered as emergency criteria on a case-by-case basis.
- 3) Maintenance of the Waiting List:

The Department for Medicaid Services shall, at least annually, update the waiting list through the following procedures:

- a) Contact the applicant or his legal representative and, if applicable, case management provider in writing to verify the accuracy of the address and phone number and continued desire to pursue placement in the AIS/MR Program. This requested information shall be received by the DMS within ten (10) days from the date of the letter, excluding holidays and weekends.

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- b) The criteria for removal from the waiting list shall be:
- 1) In situations where the whereabouts of the applicant or his legal representative is unknown, and after a documented attempt to locate, the applicant shall be removed from the waiting list.
 - 2) If the AIS/MR placement for services is offered and the applicant or his legal representative refuses the offer of placement or does not pursue the complete application process (i.e., submission of an application packet) to the DMS within sixty (60) days of the placement allocation date, without good cause, the applicant's name shall be removed from the waiting list,
 - 3) Applicant is deceased.
- c) Upon removal from the waiting list, written notification shall be mailed to the applicant or his legal representative and, if applicable, the case management provider.

Removal from the waiting list does not preclude the applicant from re-submitting a new MAP-620 at a later date.

C. Pre-Authorization Procedures

1. Informing Requirement

The client or his legal representative shall be informed that AIS/MR services are an alternative to ICF/MR/DD institutional services and shall be given a choice between AIS/MR and ICF/MR/DD services.

2. Freedom of Choice Requirement

The client or legal representative shall be offered freedom of choice of AIS/MR participating providers. This shall be so documented in the client's preliminary individual habilitation plan.

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3. Level of Care Determination

- a. All initial and recertification applications for AIS/MR services shall first be determined to meet Medicaid's Criteria for the ICF/MR/DD level of care. This includes clients who are currently in Medicaid payment status in an ICF/MR/DD facility.

Level of care determinations may cover up to a six month period. Clients being re-certified for continued participation in the AIS/MR program shall receive a level of care determination prior to the end of the certification period. Clients may be re-certified up to three weeks prior to the end of the certification period.

Medicaid reimbursement shall not be available for any waiver services provided during any period of time that the client is not covered by a valid level of care determination.

- b. The level of care shall be determined by the Peer Review Organization (PRO) in the same manner as ICF/MR/DD services. All determinations are made over the telephone from the data supplied by the case management provider. The PRO, after completion and approval of the level of care, shall complete and send a notice of certification for long term care to the case management provider. It is the responsibility of the case management provider to inform the PRO of the current end-date for recertification at the time of the telephone call to insure that the new certification period immediately follows the old certification period.

4. Application for AIS/MR Services

After obtaining the level of care determination, the case management provider shall assemble the application packet. The application packet shall include all of the following information. Evaluations shall be performed no more than three (3) months prior to the application for AIS/MR services.

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- (a) MAP-350 Form (Revised 1/92);
- (b) Level of Care Determination;
- (c) Diagnosis - shall include all five (5) axes;
- (d) Physician's history and physical exam, including a statement for the need for long term care services for the mentally retarded;
- (e) Psychological evaluation or current update. If using an update, a copy of the original evaluation shall be included;
- (f) Social evaluation and family history;
- (g) Residential Needs profiles (See Appendix);
- (h) Functional abilities and limitations;
- (i) Needed services and preliminary plan of care for meeting these needs through the AIS/MR program. Also list community resources (other than AIS/MR) which may be available to meet the needs of the client;
- (j) Prognosis and Goals; and
- (k) Preliminary Cost Worksheet;

The initial application shall be sent to the following address:

Department for Medicaid Services
Division of Patient Access and Assessment
275 East Main Street
Frankfort, KY 40621

Questions regarding the application process or status of a submitted application shall be directed to the Division of Program Services at (502) 564-5560.

The application packet is reviewed, and if approved by the Department for Medicaid Services, a written letter of approval shall be sent to the case management provider.

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5. Individual Habilitation Plan (IHP)

After receipt of the written letter of approval, the case management provider develops, with any necessary input from service providers, a second, more complete plan of care. This second plan of care is called an Individual Habilitation Plan (IHP). A copy of this form is found in the Appendix. USE OF THIS FORM IS MANDATORY FOR MEDICAID AIS/MR CLIENTS, INCLUDING BOTH NEW (AS OF 01/01/92) AND EXISTING CLIENTS. HOWEVER, FOR EXISTING CLIENTS, IT SHALL NOT BECOME MANDATORY UNTIL THE CLIENT'S SIX (6) MONTH EVALUATION PERIOD.

The case management provider shall appoint an interdisciplinary team to develop the IHP. The interdisciplinary team (IDT) shall be composed of the following persons: The client's case manager, a qualified mental retardation professional (QMRP), and social worker (Bachelor's level degree or above in social work), and a licensed psychologist (Ph.D. or Master's level degree with autonomous functioning). As necessary, designated representatives from each selected provider of services identified in the preliminary plan of care shall be consulted with regard to the IHP. Professionals or other persons who have the necessary expertise to design and review elements of the plan including those who provide training or treatment, may also be consulted. Any member of the team may serve as the QMRP, if qualified.

The client or legal representative shall also attend the IDT planning session and sign the IHP or the team consensus notes shall explain the reasons(s) for his absence. The IHP shall then be signed in Block #21 "Required Signatures for persons who did not attend the meeting."

The IDT shall initiate the IHP within five (5) working days of the client's entrance into the AIS/MR service system and the IHP shall be completed and approved by the IDT within thirty (30) working days of initiation.

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The IHP shall:

- (a) Be individualized for the client receiving AIS/MR services;
- (b) Designate a case manager within the structure of the case management provider;
- (c) Specify:
 - 1. Services needed
 - 2. Names of providers
 - 3. How often the service is to be provided (For example, daily, weekly, monthly, etc.)
 - 4. The expected duration of the service, if known;
- (d) Include all pages of the document including page 11 "Assessment and Evaluation Information";
- (e) Be kept current by updating at least every six (6) months or more often as needed by utilizing an addendum;
- (f) Be submitted to Medicaid every six (6) months. This six (6) month review may be an update with only the areas of change being rewritten. The annual IHP shall be a comprehensive, fully-developed plan, similar to the initial IHP; and
- (g) Be accompanied by a completed Cost Worksheet.

Additionally, with regard to the IHP, please note the following:

- (a) The IHP shall be reviewed and approved by Medicaid Staff to assure that the client meets the criteria to be served by the AIS/MR program and to assure that his needs can be met through the provision of AIS/MR services.
- (b) Service records shall be compared with the approved IHP during on-site reviews conducted by Medicaid staff to assure that the services being provided are in accordance with the approved IHP.
- (c) Addendums to the IHP shall be sent to Medicaid within seven (7) working days of the effective date of the change. Changes not approved shall not be reimbursed.

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- (d) A cost worksheet shall be submitted with all addendums which affect change(s) in costs.
- (e) The Master Individual Habilitation Plan shall be maintained by the case manager in a central record. All service providers shall maintain records of the goals and objectives which reflect their services and copies of pages 1-7, 10, and 11 of the IHP.

The IHP shall be submitted to the:

Department for Medicaid Services
Division of Program Services
275 East Main Street
Frankfort, KY 40621

Questions regarding the IHP should be directed to the above address: phone (502) 564-5560.

6. Recertification Applications

A re-evaluation of the client's Individual Habilitation Plan is conducted every six (6) months by the Department for Medicaid Services, Division of Program Services staff.

The case management provider shall submit the following information as indicated for the recertification application:

- (a) Individual Habilitation Plan;
- (b) Level of Care Determination;
- (c) Cost Worksheet; and
- (d) Any new evaluations necessitated by the status of the client's condition.

The recertification application shall be reviewed to assure that the client still meets level of care, costs of AIS/MR services are still within the projected costs, and that the client's IHP is adequate and appropriate to meet the client's needs.

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D. Level of Care Appeal Procedures

When the Peer Review Organization takes information over the phone for a level of care determination and the review coordinator is unable to certify the level of care, the request shall be referred to a Physician Advisor. The Physician Advisor may either 1) certify the level of care, or 2) telephone the attending physician to obtain more information.

The Physician Advisor makes the decision to certify or deny the requested level of care. If the decision is to deny the level of care, notification in writing shall be sent to the provider and the client's responsible party. This notification contains information needed to assist the various parties in requesting a reconsideration as follows:

- (1) A request for reconsideration shall be accepted by the Peer Review Organization in written form only and shall be received within sixty (60) days of the date of receipt of a continued stay denial notice or within three (3) days of an initial certification denial.
- (2) Upon receipt of a timely request for reconsideration of an adverse determination, the Peer Review office shall arrange for a reconsideration hearing to be held. Reconsideration hearings shall be held within three (3) working days after receipt of the request in cases where the client requests a reconsideration of an initial certification of long-term care, or within ten (10) working days following the receipt of the request for reconsideration of continued stay denials.
- (3) The reconsideration hearings shall consist of review of all medical records pertinent to the case in question, by one or more physicians who are:
 - (a) Not associated with the original denial;
 - (b) Not related to the client;
 - (c) Not responsible for the care of the client; and
 - (d) Have active admitting privileges at one or more hospitals in Kentucky.

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One of the above specified physicians shall act as the hearing officer.

- (4) The reconsideration hearing shall be a fair evidentiary hearing. The following criteria shall be met:
- (a) All testimony is given under oath.
 - (b) The proceedings are tape recorded.
 - (c) Cross examination is allowed.
 - (d) The hearing officer's decision is based solely upon evidence presented.
5. If the adverse determination is upheld by the reconsideration hearing, the client or his legal representative has a right to a hearing with the Department for Social Insurance. The client or his legal representative has up to forty (40) days from the date this notice is mailed to request a hearing with the Department for Social Insurance. For the client currently in Medicaid payment status, if the hearing is requested within ten (10) days of the date of this notice, Medicaid benefits shall not be terminated before the hearing is held. The right to a hearing exists even if the client terminates services prior to requesting a hearing.
- (a) The hearing is a formal proceeding meeting all due process standards.
 - (b) The client has the right to represent himself and retain legal counsel or other spokesperson during the hearing.
 - (c) The hearing is evidentiary, that is, the hearing decision is based solely on evidence presented at the hearing.
 - (d) The client or his legal representative may examine any documents to be used at the hearing both before and during the hearing.
 - (e) Adverse witnesses may be confronted and cross-examined.